Allergen Immunotherapy

[Refer to WAC 388-531-0950(10)]

Reimbursement for antigen/antigen preparation (CPT codes 95145-95149, 95165, and 95170) is per dose.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	✓ One injection (CPT code 95115 or 95117); and ✓ One antigen/antigen preparation (CPT codes 95145-95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	✓ CPT code 95144 for single dose vials; or ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	✓ CPT code 95144
Allergists who billed the complete services (CPT codes 95120-95134) and used treatment boards	✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); and ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	✓ Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	✓ Bill only the injection service

Reimbursement for an allergist billing both an injection and either CPT code 95144 or 95165 is the injection plus the fee of CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E&M) procedure code for conditions not related to allergen immunotherapy.

Psychiatric Services

[Refer to WAC 388-531-1400]

☞ **Note:** These billing instructions are not for use by Psychologists. Refer to MAA's Psychologist Billing Instructions for a description of the psychology program. To view the billing instructions online, go to http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

General Guidelines

- MAA reimburses a maximum of one psychiatric service procedure code per client, per day.
- Psychiatrists must bill using one procedure code for the total time spent on direct client care during each visit. Making inpatient rounds is considered direct client care and includes any one of the following:
  - ✓ Brief (up to one hour) individual psychotherapy (CPT codes 90804-90807, 90810-90813*, 90816-90819, and 90823-90827*);
  - ✓ Family psychotherapy (CPT code 90847);
  - ✓ Group psychotherapy (CPT codes 90853 and 90857);
  - ✓ Electroconvulsive therapy (CPT codes 90870-90871); or
  - ✓ Pharmacological management (CPT code 90862).
- When performing both psychotherapy services and an E&M service during the same visit, use the appropriate psychiatric procedure code that includes the E&M services [e.g., CPT code 90805 (outpatient psychotherapy with E&M) or CPT code 90817 (inpatient psychotherapy with E&M)].
- A psychiatrist may bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).
- MAA reimburses psychiatrists for the CPT codes listed in the following tables only when billed in combination with the diagnoses listed in the table. **For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.**
- Psychiatric sleep therapy is not covered.

***Interactive psychotherapy is limited to clients 20 years of age and younger.**

Inpatient Hospital

Inpatient CPT Codes	Must be billed in combination with:
Psychiatric Services	
90816-90822, , 90823-90829*, 90845, 90847, 90853-90871, 90899	Any MAA covered diagnosis code in the following range: **ICD-9-CM 290.0-319**
Inpatient	
99217-99239	All MAA covered diagnosis codes
Inpatient Consultation	
99251-99275	All MAA covered diagnosis codes
Case Management	
99371-99373	All MAA covered diagnosis codes

*Codes 90823-90829 are limited to clients 20 years of age and younger.

All inpatient psychiatric services must be coordinated by either the local RSN or the client's MAA managed care plan.

Outpatient Hospital

Outpatient CPT Codes	Must be billed in combination with:
Psychiatric Services	
90804- 90809, 90810- 90815*, 90845, 90847, 90853-90871, 90899 The above procedure codes (except 90862) are subject to a limit of 12 hours per client, per calendar year.	Any MAA covered diagnosis code in the following range: **ICD-9-CM 290.0-319**
Outpatient	
99201-99215	Any MAA covered diagnosis codes except **ICD-9-CM 290.0-319**
Outpatient Consultation	
99241-99245	Any MAA covered diagnosis codes except **ICD-9-CM 290.0-319**
Emergency Room Consultation	
99281-99285	All MAA covered diagnosis codes except **ICD-9-CM 290.0-319**
Nursing Facility Services	
99301-99316	All MAA covered diagnosis codes except **ICD-9-CM 290.0-319**
Domiciliary/Rest Home Services	
99321-99333	All MAA covered diagnosis codes except **ICD-9-CM 290.0-319**
Standby Services	
99360	All MAA covered diagnosis codes except **ICD-9-CM 290.0-319**
Case Management Services	
99371-99373	All MAA covered diagnosis codes

* Codes 90810- 90815 are limited to clients 20 years of age and younger.

Any other outpatient psychiatric services must be coordinated by either the local RSN or the client's MAA managed care plan.

Limitations for Inpatient and Outpatient Psychiatric Services:

- MAA does not reimburse the same provider for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits and the diagnoses are completely unrelated.

- MAA reimburses psychiatrists and psychiatric ARNPs for only those procedure codes and diagnosis codes that are within their scope of practice.

- MAA reimburses psychiatric ARNPs for the following psychiatric services only:

  - ✓ 90801 - Psychiatric Diagnostic Interview Examination;
  - ✓ 90802 - Interactive Psychiatric Diagnostic Interview Examination; and
  - ✓ 90862 - Pharmacological management.

- MAA limits outpatient psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy.

- Family therapy is covered only when the client is present.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year unless a change in the client's condition occurs resulting in a new mental health diagnosis.

- Outpatient psychiatric services are not allowed for clients on the General Assistance Unemployable (GAU) program, except for medication adjustment (CPT code 90862). GAU clients must seek psychiatric services through their local Community Mental Health Center.

- Individual psychotherapy, interactive services (CPT codes 90810-90813 and 90823-90827) may be billed only for clients age 20 and younger.

Involuntary Treatment Act (ITA)

Physicians may provide psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or psychiatrist within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT code 90801 or 90802.

- A day's rounds, along with any one of the following, constitute direct client care: narcosynthesis, brief (up to one hour) individual psychotherapy, multiple/family group therapy, group therapy, or electroconvulsive therapy.

- Payment is made if the date of service is within 30 days from the date of detention.

- An extension form is required after 20 days of care. Extension approvals can be from the Regional Support Network (RSN), as well as the state hospital.

- A court may request another physician or psychiatrist evaluation.

- The ITA form must include identification of the county of commitment, as well as some identification (signature or initials) of the County Designee completing the form. The physician or psychiatrist must complete Section I of the ITA Patient Claim Information form (DSHS 13-628x). If you need copies of this referral form, mail or fax a written request on letterhead to Department of Printing Fulfillment, Mail Stop 47100, PO Box 47100, Olympia, WA 98504-7100, fax: (360) 586-8831.

- MAA reimburses for physician and psychiatrist evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.

  ☞ **Note:** One unit = 10 minutes. A maximum of five units is allowed.

- Additional costs for court testimony are reimbursed from county ITA administrative funds.

Podiatric Services [Refer to WAC 388-531-1300]

- MAA reimburses podiatrists for:

  ✓ Those procedure codes and diagnosis codes that are within their scope of practice;
  ✓ Routine foot care only when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires an M.D., D.O., or podiatrist to perform this care.

  Examples of a medical condition include, but are not limited to:

  ➢ Limitation of ambulation due to mycosis.
  ➢ Likelihood that absence of treatment will result in significant medical complications.

  ✓ Those orthotics listed on pages K.5 and K.6. If PA or expedited prior authorization (EPA) is required, see Section I.

  ☞ **Note:** If the description of the orthotic code indicates the code is for a single orthotic or impression casting of one foot, either modifier RT or LT **must** be included on the claim. Providers must use an appropriate procedure code with the word "pair" in the description when billing for fabrications, casting, or impressions of both feet.

  ✓ An Evaluation and Management (E&M) code and an orthotic on the same day if the E&M service performed has a separately identifiable diagnosis and is documented in the client's medical record.

- Medicare does not reimburse for orthotics and casting. You may bill MAA directly for those services without submitting a Medicare denial, unless the client's Medical ID card indicates *QMB - Medicare only*, in which case the orthotics and casting is not covered by MAA.

- Biomechanical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.

Limitations

- Local nerve blocks for subregional anatomic areas (such as the ankle and foot) are included in the reimbursement for the surgical procedure and are not reimbursed separately.

- Reimbursement for debridement of nails is limited to a maximum of one treatment in a 60-day period.

- MAA reimburses podiatrists for covered, diagnostic, radiologic services of the ankle and foot only when the client is examined before the x-ray is ordered.

What is not covered?

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for unilateral condition;
- X-rays in excess of two views;
- X-rays that are ordered before the client is examined;
- X-rays for any part of the body other than the foot or ankle;
- Treatment of flat feet; and
- Treatment of fungal (mycotic) disease.

Radiology Services

[Refer to WAC 388-531-1450]

General Limitations on Radiology Services

The following services are not usually considered medically necessary and may be subject to post-pay review:

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for a unilateral condition; and
- X-rays in excess of two views.

☞ **Note:** MAA does not reimburse for radiology services with diagnosis code V72.5. Providers must bill the appropriate medical ICD-9-CM code.

MAA does not reimburse radiology claim with diagnosis code V72.5. Providers must bill the appropriate medical ICD-9-CM diagnosis.

Other Limitations

- PET Scans and MRI/MRAs are limited to one per day.
- Multiple CT Scans are allowed only if done at different times of the day or if modifiers LT or RT are attached.
- MAA does not reimburse radiologists for after-hours service codes 99050–99054.

Contrast Material

Contrast material is not reimbursed separately, except in the case of low-osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections for clients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.
- A history of asthma or allergy.
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
- Generalized severe debilitation.
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS procedure codes Q9945-Q9951. The brand name of the LOCM and the dosage must be documented in the client's record.

Radiopharmaceutical Diagnostic Imaging Agents

- When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents (Q9945-Q9951).

- MAA allows the following CPT codes for radiopharmaceutical therapy without PA: CPT codes 79101, 79445, and 79005.

Outpatient MRIs

You must bill using MAA's EPA process for all outpatient MRIs. See Section I.

Outpatient PET Scans

MAA does not accept HCPCS codes for PET scans EXCEPT G0331-G0331.

Providers **must** use one of the CPT codes from the range 78459, 78608, and 78811-78813 when billing for PET scans.

All outpatient PET scans require some form of authorization. The following PET scans require prior authorization: CPT codes G0030-G0031 and CPT codes 78459, 78608, and 78811-78813.

For details on prior authorization for PET scans, refer to Section I.

Mammograms

MAA has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (CPT code 76092 and add-on code 76083). For clients age 40 and over, one annual screening mammogram is allowed. Other screening mammograms may be allowed if determined to be medically necessary and are documented in the client's record.

Radiology Modifiers for Bilateral Procedures

- Bill the procedure on two separate lines using modifier 50 on one line only.
- Bill **modifier LT or RT** on separate lines when a radiological procedure is performed on the right and/or left side or extremity.
- Do not use modifier 50, LT, or RT if the procedure is defined as bilateral.

Anesthesia for Radiological Procedures **[Refer to WAC 388-531-0300 (2) and (7)]**

General anesthesia is allowed for radiological procedures for children and/or non-cooperative clients when the medically necessary procedure cannot be performed unless the client is anesthetized.

Providers **must** use the anesthesia CPT code 01922 when providing general anesthesia for non-invasive imaging or radiation therapy. **Do not** bill the radiological procedure code (e.g., CPT code 71010) with an anesthesia modifier to bill for the anesthesia procedure. When using CPT code 01922 for non-invasive imaging or radiation therapy:

- The client must be 17 years of age or younger; or
- A statement of the client-specific reasons why the procedure cannot be performed without anesthesia services must be kept in the client's medical record and made available to MAA on request.

Nuclear Medicine

When billing MAA for nuclear medicine, the multiple surgery rules are applied when the coding combinations listed below are billed:

- For the same client, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice; or
- With other codes that are subject to the multiple surgery rules, not just when billed in the combinations specified below:
  - ✓ CPT code 78306 (bone imaging; whole body) and CPT code 78320 (bone imaging; SPECT);
  - ✓ CPT code 78802 (radionuclide localization of tumor; whole body), CPT code 78803 (tumor localization; SPECT), and CPT code 78804 (radiopharmaceutic localization of tumor requiring 2 or more days); or
  - ✓ CPT code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT).

Consultation on X-Ray Examination

When billing a consultation, the consulting physician must bill the specific x-ray code with modifier 26 (professional component).

For example: The primary physician would bill with the global chest x-ray (CPT code 71020) or the professional component (CPT code 71020-26), and the consulting physician would bill only for the professional component of the chest x-ray (e.g., CPT code 71020-26).

Portable X-Rays

- Portable x-ray services furnished in a client's home or nursing facility and payable by MAA are limited to the following:

  ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  ✓ Chest or abdominal films that do not involve the use of contrast media; or
  ✓ Diagnostic mammograms.

- Bill for transportation of x-ray equipment as follows:

  ✓ R0070 - If there is only one patient bill one unit;

  ✓ R0075 - If there are multiple patients, **bill one unit** per individual client's claim with one of the following modifiers, as appropriate. ***You must bill using a separate claim form for each MAA client seen.*** MAA reimburses the fee for procedure code R0075 divided by the number of clients, as outlined by the modifiers in the following table:

Procedure Code	Brief Description
R0070	Transport portable x-ray
R0075-UN	Transport port x-ray multipl-2 clients seen
R0075-UP	Transport port x-ray multipl-3 clients seen
R0075-UQ	Transport port x-ray multipl-4 clients seen
R0075-UR	Transport port x-ray multipl-5 clients seen
R0075-US	Transport port x-ray multipl-6 or more clients seen

☞ **Note:** MAA's reimbursement for procedure codes R0070 and R0075 includes setup. The fee for HCPCS code R0075 is divided among the clients served, as outlined by the modifiers indicated above. If no modifiers are used for HCPCS code R0075, the code will be denied. Do not bill HCPCS code R0070 in combination with HCPCS code R0075.

Heart Catheterizations

When a physician performs cardiac catheterization in a setting where the physician does not own the equipment (e.g., a hospital or ASC), MAA reimburses providers for the appropriate **procedure code with modifier 26 (professional component) only**. To bill using either the global or technical components, providers must have a contract with MAA certifying they perform heart catheterizations in their office and that they own their own equipment.

Use cardiac catheterization and angiography to report services individually. It is not appropriate to bill with modifier 51 (multiple procedures) with any of these codes.

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid.

MAA reimburses laboratories for Medicare-approved tests only.

CLIA Certification

All facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number on file with MAA in order to receive reimbursement from MAA.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call (206) 361-2805 or write to:

Department of Health
Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, Washington 98155
(206) 361-2805
(206) 361-2813 FAX

Reference Laboratory

If a laboratory sends a specimen to a reference (outside) lab, you may bill for the reference lab. However, the reference lab provider number must be entered in the performing provider number field. The reference lab must be CLIA-certified and have an active CLIA identification number on file with MAA. Use modifier 90.

Cancer Screens (HCPCS codes G0101-G0107 and G0120-G0122)

HCPCS Code	Limitations	Payable Only With Diagnosis Code(s)
G0101	Females only *[Use for Pap smear professional services]*	V25.01 through V25.3, V25.40 through V25.9, and V76.2
G0102	Bundled	N/A
G0103	Males age 50 and older Once every 12 months	Any valid ICD-9-CM code other than high risk
G0105*	Clients at high risk for colorectal cancer One every 24 months Must use modifier 53 if procedure is discontinued.	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72.
G0106	Clients age 50 and older and not a high risk Once every 48 months	Any valid ICD-9-CM code other than high risk
G0107	Clients age 50 and older Once every 12 months (1-3 simultaneous determinations)	Any valid ICD-9-CM code other than high risk
G0120	Clients age 50 and older who are at high risk for colorectal cancer Once every 24 months Must use modifier 53 if procedure is discontinued.	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72.
G0121*	Once every 48 months	Any valid ICD-9-CM code other than high risk
G0122	None	Any valid ICD-9-CM code other than high risk

☞ **Note**: Per Medicare guidelines, MAA's payment is reduced when billed with modifier 53 (discontinued procedure).

Coding and Payment Policies

- Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.
- Physicians must bill using their provider number for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its provider number for any services performed in its facility.
- MAA reimburses for one blood draw fee (CPT code 36415-36416, or 36540) per day.
- MAA reimburses for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.
- CPT codes 85007, 85009, 85014, 85018, 85021, 85027, 85041, and 85048 are included in the complete blood count procedure.
- CPT codes 81001-81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
- CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime.
- Do not bill with modifier 26 if the description in CPT indicates professional services only.
- Reimbursement for lab tests includes handling, packaging and mailing fee. Separate reimbursement is not allowed.

Note: Laboratory claims must include an appropriate medical diagnosis code. The ordering provider must give the appropriate medical diagnosis code to the performing laboratory at the time the tests are ordered. **MAA does not reimburse a laboratory for procedures billed using ICD-9-CM diagnosis codes V72.5 and V72.6.**

Drug Screens

MAA reimburses for drug screens only when:

- ✓ Medically necessary and ordered by a physician as part of a medical evaluation; or
- ✓ Drug and alcohol screens are required to assess suitability for medical tests or treatment.

- MAA does not reimburse for drug screens to monitor any of the following:
  - ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
  - ✓ Drug or alcohol use by a client when the screen is performed by a provider in a private practice; or
  - ✓ Suspected drug use by clients living in a residential setting such as a group home.
- For clients in the Division of Alcohol and Substance Abuse (DASA) contracted methadone treatment programs, drug screens are reimbursed through a contract issued by DASA, not through MAA.

Laboratory Services Referred by Community Mental Health Center (CMHC) or DASA-Contracted Providers

When CMHC or DASA-contracted providers refer clients enrolled in an MAA managed care plan for laboratory services, the laboratory **must bill MAA directly.** The following conditions apply:

- The laboratory service is medically necessary;
- The laboratory service is **directly** related to the client's mental health or alcohol and substance abuse;
- The laboratory service is referred by a CMHC or DASA-contracted provider who has a core provider agreement with MAA; and
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis.

To bill for laboratory services, laboratories **must** put the seven-digit CMHC or DASA-contracted referring provider identification number assigned by MAA in the “referring provider” field of the claim form.

CMHC and DASA-contracted services are excluded from MAA’s managed care contracts.

Automated Multi-Channel Tests

MAA reimburses for CPT lab panel codes 80048, 80050, 80051, 80053, 80061, 80069, and 80076. The individual automated multi-channel tests are:

Procedure Code	Brief Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82550	Creatine kinase (CK)
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD) (LDH)
84075	Phosphatase, alkaline
84100	Phosphorous inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
85004	Automated diff wbc count
85007	B1 smear w/diff wbc count
85009	Manual diff wbc count b-coat
85027	Complete cbc, automated

- You may bill a combination of panels and individual tests not included in the panel. ***However, do not bill separately for any individual tests that are included in the panel.*** Duplicate tests will be denied. Panel codes must be billed if all individual tests in the panel are performed.

- Each test and/or panel must be billed on a separate line.

- All automated/non-automated tests must be billed on the same claim form when performed for a client by the same provider on the same day. For laboratory services that exceed the lines allowed per claim, see below.

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy HCFA-1500 claim forms are allowed up to 6 lines per claim. Direct entry, magnetic tape, or electronic submitters are allowed 50 lines per claim. **Use additional claim forms if the services exceed the lines allowed**. Enter the statement: "Additional services" in field 19 when billing on a hardcopy HCFA-1500 claim form or in the *Comments* section when billing electronically. Total each claim separately.

- If MAA pays a claim with one or more automated/non-automated lab tests, providers must bill any additional automated/non-automated lab tests for the same date of service on an Adjustment Request form [DSHS# 525-109]. Refer to the Important Contacts section for ordering/downloading DSHS forms. Make sure you adjust the claim with the paid automated/non-automated lab tests using the comment "**additional services.**"

Reimbursement for Automated Multi-Channel Tests

For individual automated multi-channel tests, providers are paid on the basis of the total number of individual automated multi-channel tests performed for the same client, on the same day, by the same laboratory.

- When all the tests in a panel are not performed, each test must be billed as a separate line item on the claim form.
- When there are additional automated multi-channel tests not included in a panel, each additional test must be billed as a separate line item on the claim form.
- Bill any other individual tests as a separate line item on the claim form.

Payment calculation for individual automated laboratory tests is based on the total number of automated multichannel tests performed per day, per patient. Reimbursement for each test is based on Medicare's fees multiplied by MAA's fiscal year laboratory conversion factor.

For example:

- If five individual automated tests are billed, the reimbursement is equal to the internal code's maximum allowable fee.
- If five individual automated tests and a panel are billed, MAA reimburses providers separately for the panel at the panel's maximum allowable. Reimbursement for the individual automated tests, less any duplicates, is equal to the internal code's maximum allowable fee.

If one automated multi-channel test is billed, reimbursement is at the individual procedure code or internal code's maximum allowable fee, whichever is lower. The same applies if the same automated multi-channel test is performed with modifier 91 (see page E.19 for information on modifier 91).

Non-automated Multi-Channel

Organ and disease panels (CPT codes 80055 and 80074) do not include automated multi-channel tests. If all individual tests in the panel are not performed, reimbursement is the individual procedure code maximum allowable fee or billed charge, whichever is lower.

The non-automated multi-channel tests are:

CPT Code	Brief Description
83718	Assay of lipoprotein
84443	Assay thyroid stim hormone
85025	Automated hemogram
85651	Rbc sed rate, nonautomated
86255	Fluorescent antibody, screen
86430	Rheumatoid factor test
86592	Blood serology, qualitative
86644	CMV antibody
86694	Herpes simplex test
86705	Hep b core antibody, test
86709	Hep a antibody, igm
86762	Rubella antibody
86777	Toxoplasma antibody
86803	Hep c ab test, confirm
86850	RBC antibody screen
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

Laboratory Modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT-recognized panel, other than automated profile CPT codes 80002-80019, G0058, G0059, and G0060. MAA recognizes this modifier as ***informational only***. **This modifier is *not* appropriate to use for billing repeat tests or to indicate the test was not done as a panel.**

Modifier 90

Reference (Outside) Laboratory: When a laboratory sends a specimen to a reference (outside) laboratory, the referring laboratory may bill for the reference laboratory (pass-through billing) by adding modifier 90 to the laboratory procedure code. *The reference laboratory provider number must be entered in the performing number field on the claim form. Both labs must be CLIA-certified.*

Modifier 91

Repeat Clinical Laboratory Diagnostic Test

Add modifier 91 to the laboratory procedure code when it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.

Do not use this modifier when tests are rerun:

- To confirm initial results;
- Due to testing problems with specimens or equipment;
- For any reason when a normal, one-time, reportable result is all that is required; or
- When there are standard procedure codes available that describe the series of results (e.g., glucose tolerance test, evocative/suppression testing, etc.).

Modifier 91 affects payments. Duplicate tests billed on the same day for the same client will be denied unless modifier 91 is used.

Clinical Laboratory Codes

Some clinical laboratory codes have both a professional component and a technical component. If performing only the technical component, do not bill with a modifier. The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Refer to MAA's fee schedule (section J) for those codes with both a technical and professional component.

Pap Smears

For professional services related to Pap smears, refer to the Cancer Screens Section (page E.13).

- Use CPT codes 88147-88154, 88164-88167, and P3000-P3001 for conventional Pap smears.

- MAA reimburses for thin layer preparation CPT codes 88142-88143 and 88174-88175. MAA does not reimburse providers for HCPCS codes G0123-G0124 and G0141-G0148. MAA reimburses for thin layer Paps at Medicare's payment levels. Thin layer preparation and conventional preparation CPT codes cannot be billed in combination.

- Use CPT codes 88141 and 88155 in conjunction with codes 88142-88143 and 88164-88167.

- Use the appropriate medical diagnosis if a condition is found.

- MAA reimburses providers for one routine Pap smear per client, per calendar year only. MAA considers routine Pap smears to be those billed with an ICD-9-CM diagnosis of V76.2. Any additional routine Pap smears will be denied.

- MAA does not reimburse providers for CPT code 88112 with diagnosis V72.3 or V76.2.

HIV Testing

MAA reimburses providers for HIV testing (CPT codes 87534-87539) for ICD-9-CM diagnosis codes 042 or V08 only.

STAT Lab Charges

When the laboratory tests listed on the following page are performed on a STAT basis, the provider may bill **HCPCS code S3600** (Stat laboratory request).

- Reimbursement is limited to one STAT charge per episode (not once per test).
- Tests must be ordered STAT and payment is limited to only those that are needed to manage the client in a true emergency.
- The laboratory report must contain the name of the provider who requested the STAT.
- The medical record must reflect the medical necessity and urgency of the service.

Note: "STAT" must be clearly indicated by the provider and must be documented in the laboratory report and the client's record. Tests generated from the emergency room do not automatically justify a STAT order. Use **HCPCS code S3600** with the procedure codes on the following page.

The STAT charge is paid only with the tests listed below:

Procedure Code	Brief Description
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitate/multi
80101	Drug screen, single
80156	Assay, carbamazepine, total
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of procainamide
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urnalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay, glucose, blood quant
83615	Lactate (LD) (LDH) enzyme
83663	Test urine for lactose

Procedure Code	Brief Description
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Assay of protein, other
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST)(SGOT)
84484	Assay of troponin, quant
84512	Troponin qualitative
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85004	Automated diff wbc count
85007	Differential WBC count
85027	Automated hemogram
85032	Manual cell count, each
85046	Automated hemogram
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation, vte
85384	Fibrinogen
85396	Clotting assay, whole blood
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear gram stain
87210	Smear, wet mount, saline/ink
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

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